FOR OHF USE

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# 2001
## STATE OF ILLINOIS
## DEPARTMENT OF PUBLIC AID
## FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
## (FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0038208

**Facility Name:** ANDOVER

**Address:** 4636 WEST ANDOVER (Number) PEORIA (City) 61615 (Zip Code)

**County:** PEORIA

**Telephone Number:** 309 691-1736 **Fax #** 309 689-3613

**IDPA ID Number:** 370794792004

**Date of Initial License for Current Owners:** 6/4/93

**Type of Ownership:**

| | | | | | |
|---|---|---|---|---|---|
| X | VOLUNTARY,NON-PROFIT | | PROPRIETARY | | GOVERNMENTAL |
| X | Charitable Corp. | | Individual | | State |
| | Trust | | Partnership | | County |
| IRS Exemption Code 501(C)3 | | | Corporation | | Other |
| | | | "Sub-S" Corp. | | |
| | | | Limited Liability Co. | | |
| | | | Trust | | |
| | | | Other | | |

**In the event there are further questions about this report, please contact:**
**Name** STUART SCHMITT **Telephone Number:** (309) 691-3800

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

**Officer or Administrator of Provider**
(Signed) (Date)
(Type or Print Name STUART SCHMITT
(Title) VICE PRESIDENT/CFO

**Paid Preparer**
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

| | 1 Beds at Beginning of Report Period | 2 Licensure Level of Care | 3 Beds at End of Report Period | 4 Licensed Bed Days During Report Period | |
|---|---|---|---|---|---|
| 1 | | Skilled (SNF) | | | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | | 2 |
| 3 | | Intermediate (ICF) | | | 3 |
| 4 | 16 | Intermediate/DD | 16 | 5,840 | 4 |
| 5 | | Sheltered Care (SC) | | | 5 |
| 6 | | ICF/DD 16 or Less | | | 6 |
| 7 | 16 | TOTALS | 16 | 5,840 | 7 |

B. Census-For the entire report period.

| | 1 Level of Care | 2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient | 3 Private Pay | 4 Other | 5 Total | |
|---|---|---|---|---|---|---|
| 8 | SNF | | | | | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | | | | | 10 |
| 11 | ICF/DD | 5,557 | | | 5,557 | 11 |
| 12 | SC | | | | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | 5,557 | | | 5,557 | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 95.15%

D. How many bed-hold days during this year were paid by Public Aid? 95 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [ ] NO [X]

I. On what date did you start providing long term care at this location? Date started / / SEE DATES OF INITIAL LICENSE

J. Was the facility purchased or leased after January 1, 1978? YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

## IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

Print Preview

**Facility Name & ID Number** ANDOVER # 0038208 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

| | Operating Expenses | Costs Per General Ledger | | | | Reclass-ification | Reclassified Total | Adjust-ments | Adjusted Total | FOR OHF USE ONLY | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Salary/Wage | Supplies | Other | Total | | | | | | | |
| | **A. General Services** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 1 | Dietary | | 1,482 | 1,826 | 3,308 | 36,504 | 39,812 | 19 | 39,831 | | | 1 |
| 2 | Food Purchase | | 44,180 | | 44,180 | | 44,180 | 632 | 44,812 | | | 2 |
| 3 | Housekeeping | 4,602 | 5,081 | | 9,683 | 5,294 | 14,977 | 238 | 15,215 | | | 3 |
| 4 | Laundry | | 1,253 | | 1,253 | | 1,253 | 0 | 1,253 | | | 4 |
| 5 | Heat and Other Utilities | | | 17,150 | 17,150 | | 17,150 | 2,484 | 19,634 | | | 5 |
| 6 | Maintenance | 10,120 | 7,030 | 7,846 | 24,996 | | 24,996 | 4,044 | 29,040 | | | 6 |
| 7 | Other (specify):* | | 155 | 3,413 | 3,568 | | 3,568 | 464 | 4,032 | | | 7 |
| 8 | **TOTAL General Services** | 14,722 | 59,181 | 30,235 | 104,138 | 41,798 | 145,936 | 7,881 | 153,817 | | | 8 |
| | **B. Health Care and Programs** | | | | | | | | | | | |
| 9 | Medical Director | | | 900 | 900 | | 900 | 2 | 902 | | | 9 |
| 10 | Nursing and Medical Records | 456,026 | 4,534 | 1,800 | 462,360 | (41,798) | 420,562 | 228 | 420,790 | | | 10 |
| 10a | Therapy | 8,878 | 223 | 2,553 | 11,654 | | 11,654 | 0 | 11,654 | | | 10a |
| 11 | Activities | | 222 | 2,480 | 2,702 | | 2,702 | 0 | 2,702 | | | 11 |
| 12 | Social Services | 8,611 | | | 8,611 | | 8,611 | 0 | 8,611 | | | 12 |
| 13 | Nurse Aide Training | 8,344 | 336 | | 8,680 | | 8,680 | 0 | 8,680 | | | 13 |
| 14 | Program Transportation | | | 7,664 | 7,664 | (316) | 7,348 | 0 | 7,348 | | | 14 |
| 15 | Other (specify):* | | | (986) | (986) | | (986) | 0 | (986) | | | 15 |
| 16 | | 481,859 | 5,315 | 14,411 | 501,585 | (42,114) | 459,471 | 230 | 459,701 | | | 16 |
| | **C. General Administration** | | | | | | | | | | | |
| 17 | Administrative | 17,860 | | | 17,860 | | 17,860 | 37,353 | 55,213 | | | 17 |
| 18 | Directors Fees | | | | | | | 0 | | | | 18 |
| 19 | Professional Services | | | 82 | 82 | | 82 | 3,326 | 3,408 | | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 2,475 | 2,475 | | 2,475 | 1,659 | 4,134 | | | 20 |
| 21 | Clerical & General Office Expense | 3,394 | 1,305 | 2,755 | 7,454 | 2,339 | 9,793 | 22,207 | 32,000 | | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 119,101 | 119,101 | | 119,101 | 12,763 | 131,864 | | | 22 |
| 23 | Inservice Training & Education | | | 2 | 2 | | 2 | 34 | 36 | | | 23 |
| 24 | Travel and Seminar | | | 686 | 686 | | 686 | 893 | 1,579 | | | 24 |
| 25 | Other Admin. Staff Transportation | | | | | | | 714 | 714 | | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 4,853 | 4,853 | | 4,853 | 816 | 5,669 | | | 26 |
| 27 | Other (specify):* | | | 178 | 178 | | 178 | 393 | 571 | | | 27 |
| 28 | **TOTAL General Administration** | 21,254 | 1,305 | 130,132 | 152,691 | 2,339 | 155,030 | 80,158 | 235,188 | | | 28 |
| 29 | **TOTAL Operating Expense (sum of lines 8, 16 & 28)** | 517,835 | 65,801 | 174,778 | 758,414 | 2,023 | 760,437 | 88,269 | 848,706 | | | 29 |

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.**

Print Preview

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

**V. COST CENTER EXPENSES (continued)**

| | | Cost Per General Ledger | | | | Reclass- | Reclassified | Adjust- | Adjusted | FOR OHF USE ONLY | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Capital Expense | Salary/Wage | Supplies | Other | Total | ification | Total | ments | Total | | | |
| | D. Ownership | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 30 | Depreciation | | | 20,990 | 20,990 | | 20,990 | 6,192 | 27,182 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | | | | | 0 | | | | 31 |
| 32 | Interest | | | 2,349 | 2,349 | | 2,349 | 6,000 | 8,349 | | | 32 |
| 33 | Real Estate Taxes | | | | | | | 0 | | | | 33 |
| 34 | Rent-Facility & Grounds | | | | | | | 0 | | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 2,339 | 2,339 | (2,339) | | 0 | | | | 35 |
| 36 | Other (specify):* | | | | | | | 0 | | | | 36 |
| 37 | TOTAL Ownership | | | 25,678 | 25,678 | (2,339) | 23,339 | 12,192 | 35,531 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | 316 | 316 | 0 | 316 | | | 38 |
| 39 | Ancillary Service Centers | | | | | | | 0 | | | | 39 |
| 40 | Barber and Beauty Shops | | | | | | | 0 | | | | 40 |
| 41 | Coffee and Gift Shops | | | | | | | 0 | | | | 41 |
| 42 | Provider Participation Fee | | | 52,196 | 52,196 | | 52,196 | 0 | 52,196 | | | 42 |
| 43 | Other (specify):* | | | | | | | 0 | | | | 43 |
| 44 | TOTAL Special Cost Centers | | | 52,196 | 52,196 | 316 | 52,512 | | 52,512 | | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 517,835 | 65,801 | 252,652 | 836,288 | 0 | 836,288 | 100,461 | 936,749 | | | 45 |

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**



Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

**VI. ADJUSTMENT DETAIL** **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

| | NON-ALLOWABLE EXPENSES | 1 Amount | 2 Refer-ence | 3 OHF USE ONLY | |
|---|---|---|---|---|---|
| 1 | Day Care | $ | | $ | 1 |
| 2 | Other Care for Outpatients | | | | 2 |
| 3 | Governmental Sponsored Special Programs | | | | 3 |
| 4 | Non-Patient Meals | | | | 4 |
| 5 | Telephone, TV & Radio in Resident Rooms | | | | 5 |
| 6 | Rented Facility Space | | | | 6 |
| 7 | Sale of Supplies to Non-Patients | | | | 7 |
| 8 | Laundry for Non-Patients | | | | 8 |
| 9 | Non-Straightline Depreciation | | | | 9 |
| 10 | Interest and Other Investment Income | | | | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds | | | | 11 |
| 12 | Non-Working Officer's or Owner's Salary | | | | 12 |
| 13 | Sales Tax | | | | 13 |
| 14 | Non-Care Related Interest | | | | 14 |
| 15 | Non-Care Related Owner's Transactions | | | | 15 |
| 16 | Personal Expenses (Including Transportation) | | | | 16 |
| 17 | Non-Care Related Fees | | | | 17 |
| 18 | Fines and Penalties | | | | 18 |
| 19 | Entertainment | | | | 19 |
| 20 | Contributions | | | | 20 |
| 21 | Owner or Key-Man Insurance | | | | 21 |
| 22 | Special Legal Fees & Legal Retainers | | | | 22 |
| 23 | Malpractice Insurance for Individuals | | | | 23 |
| 24 | Bad Debt | | | | 24 |
| 25 | Fund Raising, Advertising and Promotional | | | | 25 |
| 26 | Income Taxes and Illinois Personal Property Replacement Tax | | | | 26 |
| 27 | Nurse Aide Training for Non-Employees | | | | 27 |
| 28 | Yellow Page Advertising | | | | 28 |
| 29 | Other-Attach Schedule | | | | 29 |
| 30 | **SUBTOTAL (A): (Sum of lines 1-29)** | $ | | $ | 30 |

| OHF USE ONLY | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 48 | | 49 | | 50 | | 51 | | 52 | |

**B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)**

| | | 1 Amount | 2 Reference | |
|---|---|---|---|---|
| 31 | Non-Paid Workers-Attach Schedule* | $ | | 31 |
| 32 | Donated Goods-Attach Schedule* | | | 32 |
| 33 | Amortization of Organization & Pre-Operating Expense | | | 33 |
| 34 | Adjustments for Related Organization Costs (Schedule VII) | 100,461 | | 34 |
| 35 | Other- Attach Schedule | | | 35 |
| 36 | **SUBTOTAL (B): (sum of lines 31-35)** | $ 100,461 | | 36 |
| 37 | **TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))** | $ 100,461 | | 37 |

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

| | | 1 Yes | 2 No | 3 Amount | 4 Reference | |
|---|---|---|---|---|---|---|
| 38 | Medically Necessary Transport | | | $ 316 | | 38 |
| 39 | | | | | | 39 |
| 40 | Gift and Coffee Shops | | | | | 40 |
| 41 | Barber and Beauty Shops | | | | | 41 |
| 42 | Laboratory and Radiology | | | | | 42 |
| 43 | Prescription Drugs | | | | | 43 |
| 44 | Exceptional Care Program | | | | | 44 |
| 45 | Other-Attach Schedule | | | | | 45 |
| 46 | Other-Attach Schedule | | | | | 46 |
| 47 | **TOTAL (C): (sum of lines 38-46)** | | | $ 316 | | 47 |

Print Preview

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**Detail lines 29 and 35 of Page 5 starting in B44** DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

**To Print the Other Adjustments you have entered.**
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

**Print Other**

**STATE OF ILLINOIS** **Page 5A**

**Facility Name** ANDOVER
**IDPH** 0020208
**Report Period Beginning:** 07/01/00
**Ending:** 06/30/01

| | NON-ALLOWABLE EXPENSES | Amount | Sch. V Line Reference | Sch V Adj. Summary |
|---|---|---|---|---|
| | The information listed in B13 thru G43 is from Page 5. | | | |
| 1 | **Day Care** | 0 | 0 | **Line 1** 0 |
| 2 | **Other Care for Outpatients** | 0 | 0 | **Line 2** 0 |
| 3 | **Governmental Sponsored Special Programs** | 0 | 0 | **Line 3** 0 |
| 4 | **Non-Patient Meals** | 0 | 0 | **Line 4** 0 |
| 5 | **Telephone, TV & Radio in Resident Rooms** | 0 | 0 | **Line 5** 0 |
| 6 | **Rented Facility Space** | 0 | 0 | **Line 6** 0 |
| 7 | **Sale of Supplies to Non-Patients** | 0 | 0 | **Line 7** 0 |
| 8 | **Laundry for Non-Patients** | 0 | 0 | **Line 8** 0 |
| 9 | **Non-Straightline Depreciation** | 0 | 0 | **Line 9** 0 |
| 10 | **Interest and Other Investment Income** | 0 | 0 | **Line 10** 0 |
| 11 | **Discounts, Allowances, Rebates & Refunds** | 0 | 0 | **Line 10a** 0 |
| 12 | **Non-Working Officer's or Owner's Salary** | 0 | 0 | **Line 11** 0 |
| 13 | **Sales Tax** | 0 | 0 | **Line 12** 0 |
| 14 | **Non-Care Related Interest** | 0 | 0 | **Line 13** 0 |
| 15 | **Non-Care Related Owner's Transactions** | 0 | 0 | **Line 14** 0 |
| 16 | **Personal Expenses (Including Transportation)** | 0 | 0 | **Line 15** 0 |
| 17 | **Non-Care Related Fees** | 0 | 0 | **Line 16** 0 |
| 18 | **Fines and Penalties** | 0 | 0 | **Line 17** 0 |
| 19 | **Entertainment** | 0 | 0 | **Line 18** 0 |
| 20 | **Contributions** | 0 | 0 | **Line 19** 0 |
| 21 | **Owner or Key-Man Insurance** | 0 | 0 | **Line 20** 0 |
| 22 | **Special Legal Fees & Legal Retainers** | 0 | 0 | **Line 21** 0 |
| 23 | **Malpractice Insurance for Individuals** | 0 | 0 | **Line 22** 0 |
| 24 | **Bad Debt** | 0 | 0 | **Line 23** 0 |
| 25 | **Fund Raising, Advertising and Promotional** | 0 | 0 | **Line 24** 0 |
| 26 | **Income & IL Personal Property Replacement T** | 0 | 0 | **Line 25** 0 |
| 27 | **Nurse Aide Training for Non-Employees** | 0 | 0 | **Line 26** 0 |
| 28 | **Yellow Page Advertising** | 0 | 0 | **Line 27** 0 |
| 29 | **Non-Paid Workers** | 0 | 0 | **Line 28** 0 |
| 30 | **Donated Goods** | 0 | 0 | **Line 29** 0 |
| 31 | **Amortization Expense** | 0 | 0 | **Line 30** 0 |
| 32 | | | | **Line 31** 0 |
| 33 | | | | **Line 32** 0 |
| 34 | | | | **Line 33** 0 |
| 35 | | | | **Line 34** 0 |
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| 37 | | | | **Line 36** 0 |
| 38 | | | | **Line 37** 0 |
| 39 | | | | **Line 38** 0 |
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Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

| | Operating Expenses | PAGES 5 & 5A | PAGE 6 | PAGE 6A | PAGE 6B | PAGE 6C | PAGE 6D | PAGE 6E | PAGE 6F | PAGE 6G | PAGE 6H | PAGE 6I | SUMMARY TOTALS (to Sch V, col.7) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **A. General Services** | | | | | | | | | | | | | |
| 1 | Dietary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 2 | Food Purchase | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| 3 | Housekeeping | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| 4 | Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| 5 | Heat and Other Utilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |
| 6 | Maintenance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| 7 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| 8 | **TOTAL General Services** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 |
| | **B. Health Care and Programs** | | | | | | | | | | | | | |
| 9 | Medical Director | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| 10 | Nursing and Medical Records | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| 10a | Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10a |
| 11 | Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| 12 | Social Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| 13 | Nurse Aide Training | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 |
| 14 | Program Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| 15 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 |
| 16 | **TOTAL Health Care and Program** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 16 |
| | **C. General Administration** | | | | | | | | | | | | | |
| 17 | Administrative | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 17 |
| 18 | Directors Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18 |
| 19 | Professional Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 19 |
| 20 | Fees, Subscriptions & Promotions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 20 |
| 21 | Clerical & General Office Expenses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 21 |
| 22 | Employee Benefits & Payroll Taxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 22 |
| 23 | Inservice Training & Education | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 23 |
| 24 | Travel and Seminar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24 |
| 25 | Other Admin. Staff Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 26 |
| 27 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 27 |
| 28 | **TOTAL General Administration** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 28 |
| 29 | **TOTAL Operating Expense (sum of lines 8,16 & 28)** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 29 |

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

| | Capital Expense | PAGES | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | SUMMARY TOTALS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D. Ownership | 5 & 5A | 6 | 6A | 6B | 6C | 6D | 6E | 6F | 6G | 6H | 6I | (to Sch V, col.7) | |
| 30 | Depreciation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |
| 31 | Amortization of Pre-Op. & Org. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| 32 | Interest | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32 |
| 33 | Real Estate Taxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| 34 | Rent-Facility & Grounds | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| 35 | Rent-Equipment & Vehicles | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 |
| 36 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 36 |
| 37 | TOTAL Ownership | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 37 |
| | Ancillary Expense | | | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 38 |
| 39 | Ancillary Service Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 |
| 40 | Barber and Beauty Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40 |
| 41 | Coffee and Gift Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 41 |
| 42 | Provider Participation Fee | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 42 |
| 43 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 43 |
| 44 | TOTAL Special Cost Cent | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 45 |

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.



STATE OF ILLINOIS

Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning 07/01/00 Ending: 06/30/01

Show Pgs 6A thru 6B | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

| 1 OWNERS | | 2 RELATED NURSING HOMES | | 3 OTHER RELATED BUSINESS ENTITIES | | |
|---|---|---|---|---|---|---|
| Name | Ownership % | Name | City | Name | City | Type of Business |
| PEORIA ASSOCIATION FOR | 100 | NONE | | PARC, INC. | PEORIA | NFP CORP. |
| RETARDED CITIZENS, INC. | | | | PARC DEV. HOMES | PEORIA | NFP CORP. |
| | | | | PARC FOUNDATN | PEORIA | NFP CORP. |
| | | | | PARC COM. HMES | EAST PEORIA | NFP CORP. |
| | | | | PARC RES. OPTNS | PEORIA | NFP CORP. |
| | | | | PARC APTS. PROJ | PEORIA | NFP CORP. |
| | | | | PARC CHILD CAR | PEORIA | NFP CORP. |
| | | | | PARC GRP. HOME | PEORIA | NFP CORP. |

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 Schedule V | 2 Line | 3 Cost Per General Ledger Item | 4 Amount | 5 Cost to Related Organization Name of Related Organization | 6 Percent of Ownership | 7 Operating Cost of Related Organization | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|---|---|---|---|---|---|---|---|---|
| 1 | V | SEE SCH. VIII | $ 0 | PEORIA ASSOCIATION FOR RETARDED CITIZEN | 100.000% | $ 100,461 | $ 100,461 | 1 |
| 2 | V | | | | | | | 2 |
| 3 | V | | | | | | | 3 |
| 4 | V | | | | | | | 4 |
| 5 | V | | | | | | | 5 |
| 6 | V | | | | | | | 6 |
| 7 | V | | | | | | | 7 |
| 8 | V | | | | | | | 8 |
| 9 | V | | | | | | | 9 |
| 10 | V | | | | | | | 10 |
| 11 | V | | | | | | | 11 |
| 12 | V | | | | | | | 12 |
| 13 | V | | | | | | | 13 |
| 14 | Total | | $ | | | $ 100,461 | $ * 100,461 | 14 |

Sum_6
10046.1

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginnin 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

| | 1 | 2 | 3 | 4 | 5 | 6 | | 7 | | 8 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Name | Title | Function | Ownership Interest | Compensation Received From Other Nursing Homes* | Average Hours Per Work Week Devoted to this Facility and % of Total Work Week | | Compensation Included in Costs for this Reporting Period** | | Schedule V. Line & Column Reference | |
| | | | | | | Hours | Percent | Description | Amount | | |
| 1 | NONE | | | | | | | | $ | | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | $ | | 13 |

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: PEORIA ASSN. FOR RETARDED CIT.
Street Address: 1913 TOWNLINE RD., P. O. BOX 3418
City / State / Zip Code: PEORIA, IL 61612
Phone Number: ( 309) 691-3800
Fax Number: ( 309) 689-3613

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | FOOD | % OF DIRECT COST | 11,956,755 | 12 | $ 9,274 | $ | 815,298 | $ 632 | 1 |
| 2 | 3 | HOUSEKEEPING | " | 11,956,755 | 12 | 3,485 | | 815,298 | 238 | 2 |
| 3 | 5 | HEAT & OTHER UTILITIES | " | 11,956,755 | 12 | 36,431 | | 815,298 | 2,484 | 3 |
| 4 | 6 | MAINTENANCE | " | 11,956,755 | 12 | 59,300 | | 815,298 | 4,044 | 4 |
| 5 | 7 | OTHER GENERAL SERVIC | " | 11,956,755 | 12 | 6,802 | | 815,298 | 464 | 5 |
| 6 | 9 | PHYSICIAN FEES | " | 11,956,755 | 12 | 36 | | 815,298 | 2 | 6 |
| 7 | 10 | NURSING & MEDICAL REC | " | 11,956,755 | 12 | 3,348 | | 815,298 | 228 | 7 |
| 8 | 17 | ADMIN. SALARIES | " | 11,956,755 | 12 | 547,803 | 547,803 | 815,298 | 37,353 | 8 |
| 9 | 19 | PROFESSIONAL FEES | " | 11,956,755 | 12 | 51,950 | | 815,298 | 3,542 | 9 |
| 10 | 20 | FEES & SUBSCRIPTIONS | " | 11,956,755 | 12 | 24,415 | | 815,298 | 1,665 | 10 |
| 11 | 21 | CLERICAL & GENERAL | " | 11,956,755 | 12 | 284,185 | 217,228 | 815,298 | 19,378 | 11 |
| 12 | 22 | EMPLOYEE BENEFITS & T | " | 11,956,755 | 12 | 187,177 | | 815,298 | 12,763 | 12 |
| 13 | 23 | INSERVICE TRAINING & E | " | 11,956,755 | 12 | 500 | | 815,298 | 34 | 13 |
| 14 | 24 | TRAVEL & SEMINAR | " | 11,956,755 | 12 | 13,983 | | 815,298 | 953 | 14 |
| 15 | 25 | OTHER STAFF TRANSP. | " | 11,956,755 | 12 | 10,471 | | 815,298 | 714 | 15 |
| 16 | 26 | INSURANCE | " | 11,956,755 | 12 | 11,971 | | 815,298 | 816 | 16 |
| 17 | 27 | MISCELLANEOUS | " | 11,956,755 | 12 | 5,769 | | 815,298 | 393 | 17 |
| 18 | 32 | INTEREST | " | 11,956,755 | 12 | 87,989 | | 815,298 | 6,000 | 18 |
| 19 | 21 | EQUIPMENT RENTAL | " | 11,956,755 | 12 | 41,488 | | 815,298 | 2,829 | 19 |
| 20 | 30 | DEPRECIATION | " | 11,956,755 | 12 | 90,804 | | 815,298 | 6,192 | 20 |
| 21 | 1 | KITCHEN SUPPLIES | " | 11,956,755 | 12 | 283 | | 815,298 | 19 | 21 |
| 22 | 19 | UNALLOWABLE | " | 11,956,755 | 12 | (3,171) | | 815,298 | (216) | 22 |
| 23 | 20 | UNALLOWABLE | " | 11,956,755 | 12 | (87) | | 815,298 | (6) | 23 |
| 24 | 24 | UNALLOWABLE | " | 11,956,755 | 12 | (885) | | 815,298 | (60) | 24 |
| 25 | TOTALS | | | | | $ 1,473,321 | $ 765,031 | | $ 100,461 | 25 |

Print Preview

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

| | 1 | 2 | | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Name of Lender | Related** YES | Related** NO | Purpose of Loan | Monthly Payment Required | Date of Note | Amount of Note Original | Amount of Note Balance | Maturity Date | Interest Rate (4 Digits) | Reporting Period Interest Expense | |
| | A. Directly Facility Related Long-Term | | | | | | | | | | | |
| 1 | ILLINOIS DEVELOPMENT | | X | BOND FINANCING OF | VARIES | 7/2/97 | $ 8,025,000 | $ 7,490,000 | 7/1/19 | 4.50 % | $ 443,493 | 1 |
| 2 | FINANCE AUTHORITY | | | FACILITY WHICH INCLUDES | | | | | | TO | | 2 |
| 3 | | | | CORPORATE OFFICES | | | | | | 6.05 % | | 3 |
| 4 | | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | | 5 |
| | Working Capital | | | | | | | | | | | |
| 6 | | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | | 8 |
| 9 | TOTAL Facility Related | | | | | | $ 8,025,000 | $ 7,490,000 | | | $ 443,493 | 9 |
| | B. Non-Facility Related* | | | | | | | | | | | |
| 10 | | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | | 13 |
| 14 | TOTAL Non-Facility Related | | | | | | $ | $ | | | $ | 14 |
| 15 | TOTALS (line 9+line14) | | | | | | $ 8,025,000 | $ 7,490,000 | | | $ 443,493 | 15 |

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

### B. Real Estate Taxes

NONE - TAX EXEMPT

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

| | | |
|---|---|---|
| 1. Real Estate Tax accrual used on 2000 report. | $ | 1 |
| 2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.) | $ | 2 |
| 3. Under or (over) accrual (line 2 minus line 1). | $ | 3 |
| 4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.) | $ | 4 |
| 5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.) | $ | 5 |
| 6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.) | $ | 6 |
| 7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6 | $ | 7 |

Real Estate Tax History:

| Real Estate Tax Bill for Calendar Year: | | |
|---|---|---|
| | 1996 | 8 |
| | 1997 | 9 |
| | 1998 | 10 |
| | 1999 | 11 |
| | 2000 | 12 |

| | FOR OHF USE ONLY | | |
|---|---|---|---|
| 13 | FROM R. E. TAX STATEMENT FOR 2000 | $ | 13 |
| 14 | PLUS APPEAL COST FROM LINE 5 | $ | 14 |
| 15 | LESS REFUND FROM LINE 6 | $ | 15 |
| 16 | AMOUNT TO USE FOR RATE CALCULATIC | $ | 16 |

**NOTES:**

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   **This denial must be no more than four years old at the time the cost report is filed.**

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

To Print this page only

**Hold down**
**Control Key and hit r**

## 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

LYONS COURT, NORTH FROSTWOOD

FACILITY NAME ANDOVER, SOUTH FROSTWOOD COUNTY PEORIA

FACILITY IDPH LICENSE NUMBE 0038208,0038224,0038158,0038216

CONTACT PERSON REGARDING THIS REP( STU SCHMITT

TELEPHONE 309 691-3800 FAX #:309 689-3613

A. **Summary of Real Estate Tax Cost** NO TAXES PAID

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

| | (A) Tax Index Number | (B) Property Description | (C) Total Tax | (D) Tax Applicable to Nursing Home |
|---|---|---|---|---|
| 1. | | | $ | $ |
| 2. | | | $ | $ |
| 3. | | | $ | $ |
| 4. | | | $ | $ |
| 5. | | | $ | $ |
| 6. | | | $ | $ |
| 7. | | | $ | $ |
| 8. | | | $ | $ |
| 9. | | | $ | $ |
| 10. | | | $ | $ |
| | | **TOTALS** | $ 0 | $ 0 |

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Numb ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,000 B. General Construction Type: Exterior VINYL Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

| | 1 Use | 2 Square Feet | 3 Year Acquired | 4 Cost | |
|---|---|---|---|---|---|
| 1 | | 57,880 | 1992 | $ 63,900 | 1 |
| 2 | | | | | 2 |
| 3 | TOTALS | 57,880 | | $ 63,900 | 3 |

Print Preview

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 | 16 | | | 1992 | $ 537,233 | $ 13,431 | 40 | $ 13,431 | $ | $ 166,543 | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | Improvement Type** | | | | | | | | | | |
| 9 | ARCHITECT FEES | | | 1994 | 1,769 | 44 | 40 | 44 | | 477 | 9 |
| 10 | LANDSCAPING | | | 1995 | 2,000 | 200 | 10 | 200 | | 1,200 | 10 |
| 11 | LANDSCAPING & PATIOS | | | 1998 | 7,885 | 788 | 10 | 788 | | 2,760 | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | 13 |
| 14 | | | | | | | | | | | 14 |
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| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | | | | | | | | | | | 36 |

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

Print Page 12A

STATE OF ILLINOIS



Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1<br>Improvement Type** | 3<br>Year Constructed | 4<br>Cost | 5<br>Current Book Depreciation | 6<br>Life in Years | 7<br>Straight Line Depreciation | 8<br>Adjustments | 9<br>Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 37 | | | | | | | | | 37 |
| 38 | | | | | | | | | 38 |
| 39 | | | | | | | | | 39 |
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| 70 | TOTAL (lines 4 thru 69) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 70 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12B

STATE OF ILLINOIS



Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1<br>Improvement Type** | 3<br>Year Constructed | 4<br>Cost | 5<br>Current Book Depreciation | 6<br>Life in Years | 7<br>Straight Line Depreciation | 8<br>Adjustments | 9<br>Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12A, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12C

STATE OF ILLINOIS



Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1<br>Improvement Type** | 3<br>Year Constructed | 4<br>Cost | 5<br>Current Book Depreciation | 6<br>Life in Years | 7<br>Straight Line Depreciation | 8<br>Adjustments | 9<br>Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12B, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Print Page 12D

STATE OF ILLINOIS



Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1<br>Improvement Type** | 3<br>Year Constructed | 4<br>Cost | 5<br>Current Book Depreciation | 6<br>Life in Years | 7<br>Straight Line Depreciation | 8<br>Adjustments | 9<br>Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12C, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1<br>Improvement Type** | 3<br>Year Constructed | 4<br>Cost | 5<br>Current Book Depreciation | 6<br>Life in Years | 7<br>Straight Line Depreciation | 8<br>Adjustments | 9<br>Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12D, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Improvement Type** | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12E, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Improvement Type** | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12F, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Improvement Type** | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12G, Carried Forward | | $ 548,887 | $ 14,463 | | $ 14,463 | $ | $ 170,980 | 1 |
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| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Numbe ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Improvement Type** | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Totals from Page 12H, Carried Forward | | 548,887 | 14,463 | | 14,463 | | 170,980 | 1 |
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| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | $ 548,887 | $ 14,463 | | $ 14,463 | $ 0 | $ 170,980 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

## XI. OWNERSHIP COSTS (continued)

### C. Equipment Depreciation-Excluding Transportation. (See instructions.)

| | Category of Equipment | 1 Cost | Current Book Depreciation 2 | Straight Line Depreciation 3 | 4 Adjustments | Componen Life 5 | Accumulated Depreciation 6 | |
|---|---|---|---|---|---|---|---|---|
| 71 | Purchased in Prior Years | $ 12,948 | $ 1,282 | $ 1,282 | $ | 5-10 | $ 6,878 | 71 |
| 72 | Current Year Purchases | | | | | | | 72 |
| 73 | Fully Depreciated Assets | | | | | | | 73 |
| 74 | | | | | | | | 74 |
| 75 | TOTALS | $ 12,948 | $ 1,282 | $ 1,282 | $ | | $ 6,878 | 75 |

### D. Vehicle Depreciation (See instructions.)*

| | 1 Use | Model, Make and Year 2 | Year Acquired 3 | 4 Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7 Adjustments | Life in Years 8 | Accumulated Depreciation 9 | |
|---|---|---|---|---|---|---|---|---|---|---|
| 76 | CARE-RELATED | 1997 PLYMOUTH VOYAGE | 1997 | $ 19,832 | $ 2,479 | $ 2,479 | $ | 4 | $ 19,832 | 76 |
| 77 | BUSINESS/ | | | | | | | | | 77 |
| 78 | COMMUNITY ACCESS | | | | | | | | | 78 |
| 79 | | | | | | | | | | 79 |
| 80 | TOTALS | | | $ 19,832 | $ 2,479 | $ 2,479 | $ | | $ 19,832 | 80 |

### E. Summary of Care-Related Assets

| | | 1 Reference | 2 Amount | |
|---|---|---|---|---|
| 81 | Total Historical Cost | (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable) | $ 645,567 | 81 |
| 82 | Current Book Depreciation | (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) | $ 18,224 | 82 |
| 83 | Straight Line Depreciation | (line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) | $ 18,224 | 83 ** |
| 84 | Adjustments | (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable) | $ 0 | 84 |
| 85 | Accumulated Depreciation | (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable) | $ 197,690 | 85 |

### F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

| | 1 Description & Year Acquired | 2 Cost | Current Book Depreciation 3 | Accumulated Depreciation 4 | |
|---|---|---|---|---|---|
| 86 | NONE | $ | $ | $ | 86 |
| 87 | | | | | 87 |
| 88 | | | | | 88 |
| 89 | | | | | 89 |
| 90 | | | | | 90 |
| 91 | TOTALS | $ | $ | $ | 91 |

### G. Construction-in-Progress

| | Description | Cost | |
|---|---|---|---|
| 92 | | $ NONE | 92 |
| 93 | | | 93 |
| 94 | | | 94 |
| 95 | | $ | 95 |

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

## XII. RENTAL COSTS

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease NONE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

| | | 1 Year Constructed | 2 Number of Beds | 3 Date of Lease | 4 Rental Amount | 5 Total Years of Lease | 6 Total Years Renewal Option* | |
|---|---|---|---|---|---|---|---|---|
| 3 | Original Building: | | | | $ | | | 3 |
| 4 | Additions | | | | | | | 4 |
| 5 | | | | | | | | 5 |
| 6 | | | | | | | | 6 |
| 7 | TOTAL | | | | $ ** | | | 7 |

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

| | Fiscal Year Ending | Annual Rent |
|---|---|---|
| 12. | /2001 | $ |
| 13. | /2002 | $ |
| 14. | /2003 | $ |

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ Description: (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

| | 1 Use | 2 Model Year and Make | 3 Monthly Lease Payment | 4 Rental Expense for this Period | |
|---|---|---|---|---|---|
| 17 | | | $ | $ | 17 |
| 18 | | | | | 18 |
| 19 | | | | | 19 |
| 20 | | | | | 20 |
| 21 | TOTAL | | $ | $ | 21 |

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/00 Ending: 06/30/01

## XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

### A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE 80

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE 40

### B. EXPENSES

ALLOCATION OF COSTS (d)

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| | | Facility | | | |
| | | Drop-outs | Completed | Contract | Total |
| 1 | Community College Tuition | $ | $ | $ | $ |
| 2 | Books and Supplies | | | | |
| 3 | Classroom Wages (a) | | 200 | | 200 |
| 4 | Clinical Wages (b) | | 4,576 | | 4,576 |
| 5 | In-House Trainer Wages (c) | | 2,288 | | 2,288 |
| 6 | Transportation | | 1,480 | | 1,480 |
| 7 | Contractual Payments | | | | |
| 8 | Nurse Aide Competency Tests | | 136 | | 136 |
| 9 | TOTALS | $ | $ 8,680 | $ | $ 8,680 |
| 10 | SUM OF line 9, col. 1 and 2 (e) | $ 8,680 | | | |

### C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

### D. NUMBER OF AIDES TRAINED

| | |
|---|---|
| COMPLETED | |
| 1. From this facility | 8 |
| 2. From other facilities (f) | |
| DROP-OUTS | |
| 1. From this facility | |
| 2. From other facilities (f) | |
| TOTAL TRAINED | 8 |

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview